

**MANAGED HEALTH CARE IMPROVEMENT TASK FORCE  
JULY 26, 1997 STUDY SESSION - NOTES**

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**Saturday July 26, 1997  
1201 K Street, 12<sup>th</sup> floor conference room  
[California Chamber of Commerce]  
Sacramento, California**

**I. CALL TO ORDER [Chairman, Alain Enthoven, Ph.D.] - 9:40am**

The fifth Study Session of the Managed Health Care Improvement Task Force [Task Force] was called to order by Chairman, Dr. Alain Enthoven, at the Californian Chamber of Commerce building, Sacramento, California.

**II. ROLL CALL - 9:42am**

Task Force Secretary, Ms. Jill McLaughlin, took roll. The following Task Force members declared they were present: Dr. Bernard Alpert, Ms. Rebecca Bowne, Dr. Donna Conom, Ms. Barbara Decker, The Honorable Martin Gallegos, Dr. Bradley Gilbert, Ms. Diane Griffith, Mr. William Hauck, Mr. Mark Hiepler, Dr. Michael Karpf, Mr. Clark Kerr, Dr. J.D. Northway, Ms. Maryann O'Sullivan, Mr. John Ramey, Mr. Anthony Rodgers, Dr. Helen Rodriguez-Trias, Ms. Ellen Severoni, Dr. Bruce Spurlock, Mr. Ronald Williams, Mr. Allan Zaremborg, and Mr. Steven Zarkin.

Ex Officio members Ms. Kim Belshe and Ms. Marjorie Berte were also present.

**III. OPENING REMARKS - 9:45am**

Chairman Enthoven outlined the study session schedule and introduced the first report. Dr. Philip Romero informed Task Force members of the recent Fair Political Practices Commission [FPPC] determination that at this time, Task Force members are not required to comply with the FPPC's Form 700 requirement of economic disclosure. Executive Director Romero also reported that the issue of Task Force member reimbursement for travel costs associated with the attendance of Task Force meetings was tied up in the state budget process. Therefore, until further notice, the State is not authorized to reimburse members for any such travel costs. Finally, Executive Director Romero discussed a variety of policy approaches with respect to the implementation of Task Force recommendations.

**IV. DISCUSSION - 10:00am**

**A. Efforts to Continuously Improve the Quality of Health Care**

**1. Margaret Stanley[Assistant Executive Officer, Health Benefit Services, CalPERS]**

Ms. Stanley outlined the benefits of the Californian Public Employees Retirement System [CalPERS], noting that "Employees' satisfaction scores with their health plans are rising while health care costs remain stable." She stated that CalPERS provides coverage to over one million employees of state and other public agencies and their dependents. Annual health care premiums total \$1.5 billion. Ms. Stanley described four key elements of CalPERS'

success: the choice of plan and plan types; active purchasing management; the composition and leadership of the CalPERS board; and access to comprehensive, quality, and affordable benefits.

Ms. Stanley outlined CalPERS' efforts to improve the quality of health care, including participating in the California Cooperative HEDIS Reporting Initiative [CCHRI], collaborating with the Pacific Business Group on Health [PBGH] on customer satisfaction surveys, publishing an annual health plan quality and performance report, and partnering with health plans to develop best practice models, controlling costs.

Ms. Stanley stated that in the future CalPERS will focus on maintaining and increasing access, defining accountability, holding health-plans accountable, and encouraging plans to invest in information systems infrastructure. CalPERS is also considering risk adjustment.

Mr. Hauck asked several questions about costs and the seemingly incompatible aims of controlling cost while improving quality. Ms. Stanley responded that there is still a lot of fat in the system, including excess hospital beds, the number and distribution of physicians, inefficient organization and delivery of care, and administrative costs. She said that cost control and quality improvement can be complimentary: "There is still a long way to go in improving quality without cutting corners."

Ms. Bowne asked if Ms. Stanley felt that the managed care industry consolidation is hurting the choice of plans for CalPERS members. She also asked how state mandates might affect CalPERS. Ms. Stanley responded that monopoly is a concern, so CalPERS is considering alternatives such as direct contracting with doctors and hospitals, POS options, and exclusive provider organizations. She also stated that the CalPERS board has a position against mandated benefits because such mandates limit flexibility.

In response to Dr. Alpert's inquiry as to specific CalPERS recommendations for the Task Force, Ms. Stanley remarked that finding ways of making health-plans accountable for quality, access, and service should be the top priority. She also advocated a market rather than regulatory approach.

Ms. Decker asked about CalPERS' dispute resolution system. Ms. Stanley responded that CalPERS has an ombudsman that is available to members once they have exhausted or failed to get a response from their plan's appeal and grievance procedure. CalPERS contracts provide a right to an administrative hearing and hearing before the CalPERS board.

## **2. Dr. Anthony Legoretta [Vice President of Quality Initiatives, Foundation Health Systems]**

Dr. Legoretta described some of the projects undertaken by his research and development group within the HMO. They have conducted member satisfaction surveys and presented the results, by medical group and by employer, to their medical groups, contracting employers, and members. Dr. Legoretta reviewed the results of a quality improvement program to increase the rate of annual eye exams for diabetic members. He also described the group's efforts to develop specific interventions for patients with diabetes, asthma, high cholesterol, high blood pressure, or depression, by understanding the demographics of each population.

Their goal is to improve the members' quality of life, functional status, and work site absenteeism. He also presented the results of a mammography study.

Dr. Legoretta stated that "what I think we've been calling managed care for the past 15 [or] 20 years has been really managed utilization." He felt that managed care organizations need to understand the populations they serve and adapt their systems around their members' needs and wants.

Dr. Alpert asked Dr. Legoretta to identify physician incentive arrangements that he thought should be encouraged or discouraged. Dr. Legoretta responded that his plan is moving towards a performance-based physician contract structure, focusing on quality of care. They are developing similar programs for medical groups and hospitals. Dr. Legoretta also stated that dissemination of quality data to the public would be an even stronger incentive.

In response to a question from Dr. Rodriguez-Trias, Dr. Legoretta stated that there are a lot of databases that collect outcomes measures, but the timeliness of that data is "laughable."

In response to a question from Dr. Spurlock, Dr. Legoretta stated that a way to disseminate clinical practice guidelines needs to be developed. He also felt those guidelines should be disseminated to plan members.

## **B. ERG Oral Report on New Quality Information Development [Members Clark Kerr and Dr. Rodney Armstead]**

Mr. Kerr presented suggested Task Force recommendations about new quality information development. He first defined 5 audiences for health information: consumers, health providers, plan purchasers, health professionals and research efforts to improve evidence-based medicine, and policy makers.

Mr. Kerr stated that current information is inadequate. He suggested that California, in collaboration with other efforts

- develop and implement risk adjusters, perhaps in a Medicaid demonstration project;
- establish a task force to develop a strategy to move towards electronic medical records;
- move from a statutory to a regulatory approach regarding which data elements are collected;
- collect and disseminate quality information at all treatment levels [plan, hospital, medical group, etc.];
- commission a series of specific and ongoing evaluative studies, including studies on who does the best job of involving and respecting the preferences of their patients.

Dr. Spurlock suggested that the cost and feasibility of these recommendations should be analyzed. Dr. Karpf echoed this concern, stating that recommendation should be pragmatic and appropriate. Dr. Kerr stated that the health care industry currently spends about 1% to 2% of the budget on information, while other service industries devote between 6% and 8%. He asked why the health industry is complaining about the cost of information when they are "so much farther behind the rest of society."

Mr. Zatkin asked if everyone needs to move to electronic records, or if that would lead to costly data redundancies. Mr. Kerr responded that electronic records are useful for more than

just outcomes studies. They can also be used for quality improvements, such as alert systems and decision assistance. In addition, he said that after an initial investment, electronic records actually save money.

**C. ERG Oral Report on Managed Care's impact upon vulnerable populations [Members Helen Rodriguez-Trias, MD and Anthony Rodgers].**

Mr. Rodgers described several "vulnerable" groups, including the elderly; disabled children; the poor; people with long-term, chronic illnesses; "episodically vulnerable" people with serious, short-term illnesses; the working poor and medically indigent; and people who are illiterate. He questioned what proportion of the vulnerable population is in public programs such as Medicare and Medi-Cal. He also identified several roles for assisting vulnerable populations: administrative and financial intermediary, regulatory, market facilitation, and advocacy. He questioned how poor performers should be weeded out of the system.

**D. Managed Care's Impact on Women [Member Rodriguez-Trias, MD; Helen Schauffler, Ph.D., Associate Professor of Health Policy at UC Berkeley's School of Public Health; Lucette DeCorde, MPP, MPH, Director of the California Women's Health Project; and Debra Kelch, MPP].**

Dr. Rodriguez-Trias outlined the importance of women's issues in looking at managed care: women are the principle health care consumers in the country, for themselves and their families; they are the majority of the health care work force; they have been important in shaping the health care agenda through consumer groups; and they need frequent and regular care.

Dr. Schauffler described study results regarding primary and preventive care for women in California. She stated that the study set out to discover the extent the healthcare system and managed care plans in California were encouraging women to change their behaviors by offering them health advice or increasing access to health promotion programs. Dr. Schauffler described how she thought the incentives must be changed to increase counseling rates for women about their health behaviors when they visit their healthcare providers.

Dr. Schauffler stated that she would like to see the Task Force "work to begin to provide health insurance coverage and increased access to comprehensive quality managed care programs that promote health for all Californians."

Ms. DeCorde stated that mental health benefits are "woefully inadequate" and called for parity with physical health benefits. She also stated that women have less access to health coverage, due mostly to employment issues.

Ms. Kelch had several recommendations regarding managed care and older women, including: strict guidelines and quality measurements for managed care plans serving elderly and disabled persons; objective consumer information; improved provider education and licensure standards; and scrutiny of health policies for their specific impacts on older women.

***Lunch at 1:10pm***

**E. Task Force Public Survey [Helen Schauffler, Ph.D., Associate Professor of Health Policy, P.I., Health Insurance Policy Program, UC Berkeley School of Public Health]**

Dr. Schauffler described the goals of the Task Force's survey: to conduct a statistically valid survey to supplement information from public hearings; to assess the problems consumers are having; to assess the characteristics of consumers who are having problems; to assess the extent to which consumers have been able to resolve their problems and how. All of this information should assist the Task Force in identifying the most important issues and targeting solutions to those issues.

She stated that the survey is being developed in conjunction with Task Force members and a national technical advisory group of experts. She described existing surveys that would be sources for questions on the Task Force's survey. She recommended that the Consumer Assessment of Health Plans [CAHP] survey, developed by the Picker Institute and funded by the Agency for Health Care Policy and Research [AHCPR], be the core. She discussed the strengths and weaknesses of that survey. Dr. Schauffler also reviewed the proposed survey methodology and timeline. She asked Task Force to contact her with input on what topics are most important to include in the survey.

**V. ADJOURNMENT - 2:14pm**

Chairman Enthoven indicated that without objection, the study session would be adjourned. Seeing no objection, the Chairman adjourned the meeting at 2:14pm.

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**Prepared by: Stuart McVernon**